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BEFORE THE
CALIFORNIA BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: PHILIP G. MARIN, D.P.M. 1406 Park Street, #400 Alameda, CA 94501 Podiatric Medicine Certificate No. E-2182 Respondent.	No. 1B-1998-90784 OAH No. N 1999060016

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Podiatric Medicine as its Decision in the above-entitled matter.

This Decision shall become effective at 5:00 p.m. on December 10, 1999.

IT IS SO ORDERED.

DATE: November 10, 1999

Kenneth K. Phillips, Jr., D.P.M.
Acting President
Board of Podiatric Medicine

BEFORE THE
CALIFORNIA BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: PHILIP G. MARIN, D.P.M. 1406 Park Street, #400 Alameda, CA 94501 Podiatric Medicine Certificate No. E-2182 Respondent.	No. 1B-1998-90784 OAH No. N 1999060016

PROPOSED DECISION

This matter was heard on August 24 and 25, 1999, before Ruth S. Astle, Administrative Law Judge, State of California, Office of Administrative Hearing in Oakland, California.

The complainant was represented by Lynne K. Dombrowski, Deputy Attorney General.

The respondent was present and represented himself.

This matter was submitted on August 25, 1999.

FACTUAL FINDINGS

1. James H. Rathlesberger made the accusation in his official capacity as the Executive Officer of the Board of Podiatric Medicine of the State of California ("Board") and not otherwise.

2. On July 11, 1977, the Board of Podiatric Medicine issued podiatric medicine certificate number E-2182 to Philip G. Marin, D.P.M. ("respondent"). The certificate expired on May 31, 1999 and has not been renewed. The license has been previously disciplined and placed on probation to the Board as is more specifically set forth below.

3. Effective October 26, 1998, respondent's license was revoked with revocation stayed and respondent was placed on probation with various terms and conditions for a period of five years.

Drugs

4. Lidocaine hydrochloride, a dangerous drug as defined in section 4022, is used for local or regional anesthesia. Local anesthetics should only be employed by clinicians who are well versed in diagnosis and management of dose-related toxicity and other acute emergencies which might arise and then only after insuring immediate availability of oxygen, resuscitative drugs, CPR equipment, and the personnel resources needed for proper management of toxic reactions and related emergencies.

5. At all times relevant to this matter, respondent has practiced as a doctor of podiatric medicine in Alameda, California.

6. On October 16, 1998, the State Compensation Insurance Fund ("the Fund") provided the Medical Board of California with all of the medical and billing records for Patient EH[1] which it had received from respondent pursuant to subpoena.

7. The Medical Board forwarded Patient EH's records to the Board of Podiatric Medicine.

8. The records reflect that EH came to respondent with complaints of pain in both arms and wrists.

9. Respondent first treated Patient EH on July 20, 1998.

10. The lists of daily cash receipts from respondent's record book, which the Board obtained from a federal probation officer, reflect that EH had contact with respondent as early as June 8, 1998. The record book records payments of $45.00 each made by EH on June 8, 1998, July 3, 1998, August 3, 1998, August 10, 1998, September 10, 1998, and September 24, 1998. These payments were for a dietary supplement (Equinox) that respondent was selling.

11. In a personal injury questionnaire filled out by EH for respondent and dated July 20, 1998, EH reported the following symptoms: sleeping problems, tension, irritability, numbness in fingers, hands cold, and shooting pains in both hands. She made no reference to symptoms of the foot or ankle.

12. Respondent's July 20, 1998 written "assessment" of EH reflected 1) carpal tunnel, 2) ganglionic cyst, 3) tendonitis elbow and his written "plans" reflected trigger

[1] The patients' initials have been substituted for the name to protect the patients' privacy.

point injections with 3.5 cc xylocaine. He made no reference in either his assessment or his plans to concerns of the foot or ankle.

13. Respondent's records for EH include a form signed by respondent dated July 20, 1998 addressed to "whom it may concern" which states that EH has been under his care for painful wrists and that he has diagnosed her with ganglionic cysts, tendonitis, myositis in both arms, and carpal tunnel. The form reflects that EH would be able to return to light duty at work on November 26, 1998. Respondent made no reference in this letter to any concerns of the foot or ankle.

14. Respondent's progress notes for EH, in which each entry has been initialed or signed by respondent, reflect that respondent saw EH on July 27, 1998, July 30, 1998, August 3, 1998, August 6, 1998, August 13, 1998, August 18, 1998, August 20, 1998, August 23, 1998 (a Sunday), August 27, 1998, August 31, 1998, September 1, 1998, September 8, 1998, September 18, 1998, September 24, 1998, and September 28, 1998, that she had complaints concerning both wrists and arms associated with movement, grasping, and reaching, that he observed slight swelling medially at the scaphoid radial joint, and that he had diagnosed her with degenerative osteoarthritis, ganglionic cyst at the scaphoid radial joint, tendonitis, ligamentous inflammation, and myositis of the muscles of both arms. The progress notes reflect that on each of these dates respondent treated EH's wrist and arm condition with strapping, ultrasound, and trigger point injections and conducted range of motion exams and muscle testing. Respondent made no reference in his progress notes to the diagnosis or treatment of conditions of the foot or ankle.

15. On August 17, 1998, respondent ordered x-rays of EH's wrists.

16. In a letter to Unum Life Insurance Company of America ("Unum") signed by respondent and dated September 28, 1998, respondent stated that EH had been under his care for her wrist discomfort. He noted that "[a]fter working as a typist and key punching for several years [EH] develop[ed] pain of both her wrist and forearms."

17. Under "Physical Examination," the September 28, 1998 letter to Unum includes, among other things:

> "Range of Motion: Internal and external rotation at the arms and wrist was painful, flexsion [*sic*] and extension of the wrist was painful. Patient could flex at the tarsal and phlangeal [*sic*] area but could not grasp with force sufficient to pick [up] or hold 1/2 lb or over." The letter makes no reference to the range of motion of EH's feet or ankles.

"Neurologic Assessment: Sharp dull sensation of both arms was deminished [*sic*], reflexes deminished [*sic*] bilaterally. Palpation of the wrist and forearm was acutely uncomfortable. This suggested inflammation of tissues surrounding the lateral nerves and other structures of the arms and wrist." The letter makes no reference to a neurologic assessment of EH's feet or ankles.

"Musculoskeletal: There was muscular tenderness at the the [*sic*] forearm." The letter makes no reference to a musculoskeletal assessment of EH's feet or ankles.

18. Respondent stated his diagnosis of EH in the September 28, 1998 letter to Unum as ganglionic cyst and tendonitis and he stated in the "Discussion and Opinion" section of the letter that "[t]here is no doubt that Ms [H] suffered from carpa[l] tunnel syndrome, the difficulty has rendered this patient temporarily disable[d]. This restriction of joint motion becomes a problem when the supporting structures are injured. This patient is encourage[d] to see the surgeon, with consideration of surgery." Nowhere in his "Discussion and Opinion" did respondent refer to EH's feet or ankles.

19. The only reference to lower extremities at all in the September 28, 1998 letter to Unum is under "Vascular Evaluation," where it states "[s]he had normal posterior tibial, popliteal and dorsalis pedis pulses of both lowere [*sic*] extremities."

20. While the only treatments reflected in respondent's progress notes for EH are strapping, ultrasound, and trigger point injections with 3.5 cc xylocaine, the September 28, 1998 letter to Unum states that EH was treated with electrical stimulation, iontophoresis, strapping, ultrasound, Motrin 600 mg., Vicodin ES, and Valium 10 mg.

21. Respondent's records for EH contain two undated letters to "whom it may concern," both signed by respondent. Both state that EH has been under his care for complaints of painful wrists, that he has diagnosed her with carpal tunnel syndrome, ganglionic cyst, ligamentous strain, and tendonitis, and that the diagnoses have rendered her unable to perform her normal job functions. The letters describe pain with holding, grasping, and reaching out, pain at the fingertips with long term dangling of arms, and pain when lifting over two pounds. The letters describe EH as currently disabled with guarded prognosis.

22. In a letter to "whom it may concern" signed by respondent and dated September 28, 1998, respondent stated that EH had been under his care with complaints of "painful ganglionic cyst and carpal tunnel syndrome ligamentous and tendonitic strain." He stated that EH had severe pain with digital flexion, grasping, and reaching out so he had advised her to avoid these activities. He noted that EH was currently disabled and that her prognosis remained guarded.

23. Respondent does not have a physician's and surgeon's certificate to practice medicine in the state of California.

24. Respondent's master billing record for EH dated September 26, 1998 reflects as follows:

DATE	SERVICE CODE	CHARGE	PAID	BALANCE
7/27/98	97128, 95851	80.00	40.00	40.00
7/30/98	97014, 29540	80.00	40.00	80.00
8/03/98	95851	40.00	40.00	80.00
8/06/98	97014, 29540	40.00	40.00	120.00
8/13/98	97128	40.00	40.00	120.00
8/18/98	97014, 29540	80.00	40.00	160.00
8/20/98	97128	40.00	40.00	160.00
8/23/98	97014	40.00	40.00	160.00
8/27/98	97128	40.00	40.00	160.00
8/31/98	97014, 29540	80.00	40.00	200.00
9/01/98	97128	40.00	40.00	200.00
9/08/98	97014, 29540	80.00	40.00	240.00
9/18/98	95851	40.00	40.00	240.00
9/24/98	97014, 29540	80.00	40.00	260.00
9/28/98	95851	40.00	40.00	260.00

25. Individual billing forms, however, reflect different dates, different service codes, and different charges, as follows:

DATE	SERVICE CODE	CHARGE	PAID	BALANCE
7/27/98	99212	40.00	40.00	0
7/30/98	99201, 99211	40.00	40.00	0
8/09/98	99201, 99211	30.00 (?)	30.00 (?)	0
8/24/98	99201, 99211	45.00	45.00	0
8/31/98	99201, 99211	45.00	45.00	0
9/01/98	99201, 99211	45.00	45.00	0
9/08/98	99201, 99211	45.00	45.00	0
9/18/98	99201, 99211	45.00	45.00	0
9/24/98	99201, 99211	40 or 45	40 or 45	0
9/28/98	99201, 99211	40 or 50	40 or 50	0

26. On October 30, 1998, respondent's Podiatric Board probation officer, Everett Gremminger, an investigator for the Board of Podiatric Medicine, telephoned respondent and advised him that he would be scheduling an interview to be attended by Investigator Gremminger, the podiatric medical consultant Jerry Erben, D.P.M., and respondent.

27. On November 2, 1998, Investigator Gremminger telephoned respondent and left a message telling him that the interview would be held November 10, 1998 at 12:30 p.m. and asking him to bring, among other things, all his files concerning Patient EH.

28. On November 4, 1998, Investigator Gremminger wrote a letter to respondent advising him again of the November 10, 1998 interview date and again describing the materials he was expected to bring to the interview.

29. At the November 10, 1998 interview, respondent told Investigator Gremminger and Dr. Erben that the reason he had agreed to treat EH was as a favor to one of his patients. This patient told him that no other physician had been able to provide EH with relief.

30. Initially, respondent told Investigator Gremminger and Dr. Erben that EH had come to him for plantar fasciitis. When it was pointed out to him, however, that there was no mention of plantar fasciitis in EH's medical records, respondent changed his story. He said that he had treated EH's wrists with trigger point injections in the belief that he could do so under the aegis of acupuncture. He admitted, however, that he had had no training in acupuncture, had taken no courses in acupuncture, and had no acupuncture license. He then stated that his acupuncture claim was a mistake, that it was "all a mistake."

31. Respondent admitted to Investigator Gremminger and Dr. Erben that he had authored the undated letters to "whom it may concern" in which he stated that Patient EH had been under his care for her complaint of painful wrists, reported her diagnoses as carpal tunnel syndrome, ganglionic cyst, ligamentous strain, and tendonitis, described the severe pain she experienced with digital flexion, grasping, and reaching out, and proclaimed her to be disabled.

32. Respondent admitted to Investigator Gremminger and Dr. Erben that he had authored the September 28, 1998 letter to "whom it may concern" in which he stated that Patient EH had been under his care for complaints of a painful ganglionic cyst, carpal tunnel syndrome, and ligament and tendon strain, described the severe pain she experienced with digital flexion, grasping, and reaching out, and proclaimed her to be disabled.

33. Respondent also admitted that he had written and signed the September 28, 1998 letter to Unum in which he stated, among other things, that EH had been under his care for her wrist discomfort.

34. Respondent admitted to Investigator Gremminger and Dr. Erben that he had treated EH for her upper extremity problems, that he knew that he was practicing beyond the scope of his license, and that he had no explanation as to why he had provided treatment beyond the scope of his podiatric medicine license. However, he somehow justified his actions by claiming that he did not charge the patient for treating her upper extremities.

35. As directed, respondent brought his file on patient EH to the November 10, 1998 interview. Respondent's file did not contain any records not already in the possession of the Board and, except for some of the billing records and the lists of daily cash receipts for professional services from respondent's record book, respondent's file contained all of the records in the possession of the Board.

36. The initial Accusation in this matter was filed and served on respondent on April 26, 1999.

37. On June 5, 1999, respondent provided the Board with a number of documents pursuant to its request for discovery. Among the documents provided were letters and medical records relating to respondent's treatment of EH.

38. In his cover letter to the Board dated June 3, 1999, respondent stated that, among other things, he was providing the Board with "corrected and uncorrected billings given to the insurance [company]. The uncorrected billing given the insurance [company] by the patient. Included are corrected and uncorrected reports."

39. Respondent provided the Board with a letter signed by him and dated October 5, 1998 to "Num (sic) [Unum] Life Insurance Company of America" in which he stated that his office had provided the insurance company with records which were not reflective of the services he had provided to EH. Respondent claimed in the letter that the records previously provided were drafts which had been given to his typist to correct "erroneous sentences," that he had seen the patient with complaints of painful ankles, and that he had practiced only within the scope of his podiatric medicine license. He noted that he was sending the insurance company "corrected records." The Board had not previously seen this letter.

40. The "corrected records" referenced in the October 5, 1998 letter to Unum were not among the records respondent brought to his November 10, 1998 interview with Investigator Gremminger and Dr. Erben despite the fact that Investigator

Gremminger had told him to bring ***all*** files concerning Patient EH. Moreover, respondent made no reference to these "corrected records" or to their contents during the November 10, 1998 interview.

41. Among the "corrected records" was a prescription form signed by respondent and dated July 20, 1998 for x-rays of EH's foot. The only prescription form for x-rays previously provided to the Board was for x-rays of EH's wrists.

42. Among the "corrected records" was a letter to "whom it may concern" signed by respondent and dated September 28, 1998. This letter is very similar in form to the "uncorrected" September 28, 1998 letter described above. The "corrected" letter, however, states that EH was under respondent's care for complaints of her lower extremities rather than of her wrists and arms, and that she was under the care of Dr. Sheryl [Shirley] Tucker Harris for her ganglionic cyst, carpal tunnel syndrome, and ligament and tendon strain which, in the original, "uncorrected," September 28, 1998 letter, respondent had claimed to be treating himself. The "corrected" letter states, as does the "uncorrected" letter, that EH described severe pain with digital flexion, grasping, and reaching out but the "corrected" letter adds the admonition that restrictions related to EH's upper extremities would have to be deferred to Dr. Harris for comment. Finally, the "corrected" letter states that EH has swelling and tenderness of the ankles, that she was to avoid long standing, and that she was currently disabled due to the problems with her lower extremities. The "uncorrected" September 28, 1998 letter to "whom it may concern" made no reference to EH's lower extremities.

43. Among the "corrected records" was a letter to Unum signed by respondent and dated September 28, 1998, in which respondent stated that EH had been under his care for her foot and ankle pain. This letter is very similar in form to the "uncorrected" September 28, 1998 letter to Unum described, above, in which respondent stated that EH was under his care for wrist problems. Respondent noted in the "corrected" letter, as he had in the "uncorrected" letter, that "[a]fter working as a typist and key punching for several years [EH] develop[ed] pain of both her wrist and forearms." In the "corrected" letter, however, respondent added that EH "also [had] painful ankle and knee with long standing and walking." As noted above, the "uncorrected" letter refers only to the diagnosis and treatment of EH's upper extremity complaints while the "corrected" letter reflects only treatment of lower extremity complaints.

44. The "corrected" September 28, 1998 letter to Unum states, under "Past Medical History," "Musculoskeletal: Painful left knee and ankle" and "Neurological: Admits to tingling pain of her forearm and wrist and lowere [*sic*] legs and ankle."

45. Under "Physical Examination," the "corrected" September 28, 1998 letter to Unum states, among other things:

"Range of Motion: Inversion and eversion (sic) motion was painful right greater than left. Dorsiflexsion [*sic*] of the and [*sic*] plantarflexsion [*sic*] was painful right greater than left."

"Gait: The patient walked with a limp all with the purpose of avoiding further inflammation of the post injured lateral site of the right knee and ankle. With strapping she was able to ambulate about a 1/2 block then She [*sic*] had to stop or slow down in order not to over stress the turgor of the strapping. She also experienced radiating pain on the right leg after prolong[ed] walking or standing."

"Neurologic Assessment: Sharp dull sensation of the was [*sic*] deminished [*sic*], reflexes on the right deminished [*sic*] and left was normal. Palpation of the lateral right foot was acutely uncomfortable. This suggested inflammation of the tissues surrounding the lateral nerves and other structures of the right knee and ankle."

"Musculoskeletal: There was muscular tenderness at the the [*sic*] forearm through out the, [*sic*] painful ankle with dorseflexsion [*sic*] and plantarflexsion [*sic*] inversion and eversion, right greater than left."

46. Respondent's "Diagnosis" in the "corrected" September 28, 1998 letter to Unum was:

"1. Ganglionic cyst, tendonitis, Ankle

"2: possible tenosynovitis ankle right

"3: painful wrist suggestive of carpal tunnel syndrome as per Dr Harris

"4: lateral knee pain

"5: possible rheumatiod [*sic*] arthritis. bilateral [*sic*] ankle."

47. Respondent stated in the "Discussion and Opinion" section of the "corrected" September 28, 1998 letter to Unum that "[t]here is no doubt that Ms [H] suffered from severe pain to her ankles and knee. The resulting right knee and ankle [*sic*] has made ambulation difficult and has rendered this patient temporarily disable[d]. There is pain with inversion, eversion plantar and dorseflexion [*sic*] of the ankle. Weight baring [*sic*] is a problem when the supporting structures are inflamed. This patient['s] medical problems will be discussed with Dr. Harris and further diagnostic

consideration will be discussed. This patient has not progressed sufficiently at this times [*sic*] and has not been release[d] from my care [at] this time."

48. Also among the "corrected records" respondent provided to the Board on June 5, 1999 was a master billing record for EH dated September 26, 1998 which reflects different dates, service codes, and charges than the master billing record also dated September 26, 1998 described, above.

49. The "corrected" master billing record for EH reflects as follows:

DATE	SERVICE CODE	CHARGE	PAID	BALANCE
7/20/98	29540	40.00	40.00	40.00
7/27/98	99212	40.00	40.00	00.00
7/30/98	99212	40.00	40.00	00.00
8/09/98	99212	40.00	40.00	00.00
8/18/98	99212, 29540	80.00	40.00	40.00
8/20/98	99212	40.00	40.00	80.00
8/24/98	99212, 29540	80.00	40.00	120.00
8/27/98	97128, 99212	40.00	40.00	120.00
8/31/98	99212	40.00	40.00	00.00
8/27/98	99212	40.00	40.00	00.00
8/31/98	99212	40.00	40.00	00.00
9/01/98	99212	40.00	40.00	00.00
9/08/98	99212	40.00	40.00	00.00
9/18/98	99212	40.00	40.00	00.00
9/24/98	99212	40.00	40.00	00.00
9/28/98	99212	40.00	40.00	00.00
			Total Balance	120.00

50. Also among the "corrected records" respondent provided to the Board on June 5, 1999 were progress notes for EH, initialed by respondent, which were very similar in form to the "uncorrected" progress notes described above. The "corrected" progress notes reflect that EH complained of ankle pain and that respondent treated her on July 20, 1998, July 27, 1998, July 30, 1998, August 3, 1998, August 9, 1998, August 18, 1998, August 20, 1998, August 24, 1998, August 27, 1998, August 27, 1998 (there are two entries for August 27), August 31, 1998, August 31, 1998 (there are two entries for August 31),[2] September 1, 1998, September 8, 1998, September 18, 1998, September 24, 1998, and September 28, 1998 with strapping, ultrasound, and trigger point injections and periodically conducted range of motion exams and muscle testing. The

[2] Respondent admitted that he did not treat the patient twice on the dates where there were two entries. He claimed that this was another mistake.

"uncorrected" progress notes refer only to the diagnosis and treatment of EH's upper extremity complaints.

51. The "corrected" progress notes reflect that respondent observed slight swelling medially and laterally at the ankle joint and that respondent had diagnosed EH with degenerative osteoarthritis, ganglionic cyst at the anterior lateral ankle, tendonitis of both wrists, ligamentous in flammation, myositis of the muscles of both arms, and myositis of both gastrocnemius (calf) muscles.

52. The first of the two entries for August 27, 1998 in the "corrected" progress notes reflects that EH complained of both ankle pain and wrist pain. No other reference was made in this entry to EH's wrist pain. The first of the two progress note entries for August 31, 1998 also reflects that EH complained of both ankle pain and wrist pain. This entry states that EH "was told that [*sic*] see her internist and that I,d [*sic*] see her for her lower extremity only." These are the only references to upper extremity pain in the "corrected" progress notes.

53. Also among the "corrected records" respondent provided to the Board on June 5, 1999 is a modified copy of his July 20, 1998 written "assessment" and "plans" as described above. In the "corrected" document, respondent augmented the "uncorrected" assessment of EH, which reflected carpal tunnel, ganglionic cyst, and tendonitis of the elbow, with "tardal [*sic*] tunnel ankle right" and augmented the "uncorrected" plans, which reflected trigger point injections with 3.5 cc xylocaine, with, among other things, x-rays of the foot and ankle.

54. Also among the "corrected records" respondent provided to the Board on June 5, 1999 is a copy of a form which includes a category of "Chief Complaints" under which EH has written, in her own handwriting, "pains in both hands/wrists with numb-ness & swelling" and to which respondent has added, in his handwriting, "painful knees with standing" and "painful ankle right greater than left."

55. Respondent claimed that he did not re-create the medical records fraudulently, but did so in order to correct "inadvertent" mistakes. However, the "mistakes" were so extensive and pervasive that it is not credible that these "mistakes" were inadvertent. Further, respondent admits to treating the patient's wrists and arms including an injection to that area. If, in fact, these were inadvertent mistakes, respon-dent would have demonstrated complete incompetence. There is some evidence that respondent may have a psychological or physical disability that is interfering with his ability to practice podiatric medicine. It would not be in the public interest to grant respondent a probationary license at this time. Before respondent considers filing an application for reinstatement, he should undergo a complete psychological and physical evaluation and follow any recommendations made by the health care professionals.

56. Costs were certified in the amount of $1,274.10 for investigation services. This amount is reasonable. Costs were certified in the amount of $13,050.00 for prosecution by the Deputy Attorney General. There was no evidence presented to refute the reasonableness of these charges. Considering the number of documents in this case the amount is reasonable.

LEGAL CONCLUSIONS

First Cause for Discipline

(General Unprofessional Conduct, Violation of Medical Practice Act, Practicing Medicine Without Certificate)

1. By reason of the matters set forth in Findings 8 through 34, cause for disciplinary action exists pursuant to Business and Professions Code section 2234 and subsection (a) of section 2234, in conjunction with sections 2222 and 2497(a), for general unprofessional conduct and violating the medical practice act, respectively, in that respondent has violated section 2052 by exceeding the scope of the practice of podiatric medicine as described in section 2472 by diagnosing, treating, and prescribing for Patient EH's wrist and arm conditions and injuries.

Second Cause for Discipline

(Gross Negligence, Repeated Negligent Acts, Failure to Maintain Adequate and Accurate Records)

2. By reason of the matters set forth in Findings 6 through 54, cause for disciplinary action exists pursuant to Business and Professions Code section 2234, in conjunction with sections 2222 and 2497(a), for unprofessional conduct pursuant to sections 2234, subsections (b) and (d) for gross negligence and repeated acts of negligence, respectively, and section 2266, in that his medical records and billing reports for Patient EH are inconsistent with respect to the date of her first visit, the dates of her subsequent visits, what treatments he was providing her, and how much and for which visits and what treatments he was billing her.

Third Cause for Discipline

(Dishonesty, Fraudulently Altering or Modifying Medical Records, Fraudulently Creating False Medical Records, Making a False Document Related to the Practice of Podiatric Medicine)

3. By reason of the matters set forth in Findings 6 though 54 cause for disciplinary action exists pursuant to Business and Professions Code section 2234, in conjunction with sections 2222 and 2497(a), for unprofessional conduct pursuant to

section 2234(e) for dishonesty, 2261 for knowingly making or signing documents directly related to the practice of podiatry which falsely represented the facts, and 2262 for altering and modifying medical records with fraudulent intent and for creating false medical records with fraudulent intent, in that, after being formally accused by the Board of Podiatric Medicine with practicing outside the scope of his license, he created new medical records for EH and modified old ones and provided them to the Board to prove that he had not provided treatment for EH's complaints concerning her wrists and arms.

Other Matters

4. The matters set forth in Finding 54 have been considered in making the following order.

Costs

5. The costs of $1,274.10 for investigative services and Attorney General charges of $13,050.00 are granted pursuant to section 125.3 of the Business and Professions Code.

ORDER

1. Certificate number E-2182 issued to Philip G. Marin is hereby revoked pursuant to Determinations 1, 2, and 3, separately and jointly.

2. Respondent is ordered to pay the Board the actual and reasonable costs of the investigation and prosecution of this case in the amount of $14,324.10.

DATED: September 23, 1999

Ruth S Astle

RUTH S. ASTLE
Administrative Law Judge
Office of Administrative Hearings

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO July 7 1999
BY Eileen Kapustin ASSOCIATE

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BEFORE THE
CALIFORNIA BOARD OF PODIATRIC MEDICINE
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	No. 1B-1998-90784
PHILIP G. MARIN, D.P.M. 1406 Park Street, #400 Alameda, CA 94501	FIRST AMENDED ACCUSATION
Podiatric Medicine Certificate No. E-2182	
Respondent.	

The Complainant alleges:

PARTIES

1. Complainant, James H. Rathlesberger, is the Executive Officer of the Board of Podiatric Medicine of the State of California ("board") and brings this accusation solely in his official capacity.

2. On or about July 11, 1977, the Board of Podiatric Medicine issued podiatric medicine certificate number E-2182 to Philip G. Marin, D.P.M. ("respondent"). The current expiration date of the license is May 31, 1999. The license has been previously disciplined and respondent is currently on probation to the board as is more specifically set forth below.

3. Effective October 26, 1998, respondent's license was revoked with revocation stayed and respondent was placed on probation with various terms and conditions for a period of five years.

JURISDICTION

4. Section 2222 of the Business and Professions Code[1/] provides that the California Board of Podiatric Medicine shall enforce and administer Article 12 (sections 2220 et seq., found in chapter 5 of division 2 of the Business and Professions Code) as to doctors of podiatric medicine and that any acts of unprofessional conduct or other violations proscribed by the chapter are applicable to licensed doctors of podiatric medicine. Section 2222 further provides that wherever the Medical Quality Hearing Panel established under Government Code section 11371 is vested with the authority to enforce and carry out this chapter as to licensed physicians and surgeons, the Medical Quality Hearing Panel also possesses the same authority as to licensed doctors of podiatric medicine.

5. Section 2227 provides, in pertinent part, that a licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing panel may be required to pay the costs of probation monitoring if he or she is placed on probation.

6. Section 2497(a) of the Code provides that "[t]he board may order the denial of an application for, or the suspension of, or the revocation of, or the imposition of probationary conditions upon, a certificate to practice podiatric medicine for any of the causes set forth in Article 12 (commencing with Section 2220) in accordance with Section 2222."

7. Subsection (a) of section 2472 of the Code provides that the certificate to practice podiatric medicine authorizes the holder to practice podiatric medicine; subsection (b) of section 2472 provides that "[a]s used in this chapter, 'podiatric medicine' means the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human

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1. All statutory references are to the Business and Professions Code, unless otherwise stated.

foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot."

8. Section 2052 of the Code provides, in pertinent part, that any person who practices or attempts to practice any system or mode of treating the sick or afflicted or who diagnoses, treats, or prescribes for any ailment or injury without being authorized to perform that act pursuant to a certificate obtained in accordance with some provision of law is guilty of a misdemeanor.

9. Section 2234 of the Code provides, in pertinent part, that unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts.

". . . .

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon."

10. Business and Professions Code section 2261 provides that "[k]nowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

11. Business and Professions Code section 2262 provides, in pertinent part, that "[a]ltering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct."

12. Section 2266 of the Code provides that the failure to maintain adequate and accurate records relating to the provision of services to a patient constitutes unprofessional conduct.

13. Section 14124.12 of the Welfare and Institutions Code provides, in pertinent part, that: (a) no funds appropriated by this act may be expended to pay any Medi-Cal claim for any service performed by a physician while that physician's license is under suspension or revocation due to a disciplinary action of the Medical Board of California; and, (b) no funds appropriated by this act may be expended to pay any Medi-Cal claim for any surgical service or other invasive procedure performed on any Medi-Cal beneficiary by a physician if that physician has been placed on probation due to a disciplinary action of the Medical Board of California related to the performance of that specific service or procedure on any patient, except in any case where the board makes a determination during its disciplinary process that there exist compelling circumstances that warrant continued Medi-Cal reimbursement during the probationary period.

14. Section 2497.5 provides, in pertinent part, that "[t]he board may request the administrative law judge, under his or her proposed decision in resolution of a disciplinary proceeding before the board, to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case."

DRUGS

15. Lidocaine hydrochloride, a dangerous drug as defined in section 4022, is used for local or regional anesthesia. Local anesthetics should only be employed by clinicians who are well versed in diagnosis and management of dose-related toxicity and other acute emergencies which might arise and then only after insuring immediate availability of oxygen, resuscitative drugs, CPR equipment, and the personnel resources needed for proper management of toxic reactions and related emergencies.

FACTS

16. At all times relevant to this matter, respondent has practiced as a doctor of podiatric medicine in Alameda, California.

17. On or about October 16, 1998, the State Compensation Insurance Fund

("the Fund") provided the Medical Board of California with all of the medical and billing records for Patient EH[2/] which it had received from respondent pursuant to subpoena.

18. The Medical Board forwarded Patient EH's records to the Board of Podiatric Medicine.

19. The records reflect that EH came to respondent with complaints of pain in both arms and wrists.

20. Respondent claims that he first treated patient EH on July 20, 1998.

21. The lists of daily cash receipts for professional services from respondent's record book, however, which the board obtained from a federal probation officer, reflect that EH saw respondent as early as June 8, 1998. The record book records payments of $45.00 each made by EH for office visits on June 8, 1998, July 3, 1998, August 3, 1998, August 10, 1998, September 10, 1998, and September 24, 1998.

22. In a personal injury questionnaire filled out by EH for respondent and dated July 20, 1998, EH reported the following symptoms: sleeping problems, tension, irritability, numbness in fingers, hands cold, and shooting pains in both hands. She made no reference to symptoms of the foot or ankle.

23. Respondent's July 20, 1998 written "assessment" of EH reflected 1) carpal tunnel, 2) ganglionic cyst, 3) tendonitis elbow and his written "plans" reflected trigger point injections with 3.5 cc xylocaine. He made no reference in either his assessment or his plans to concerns of the foot or ankle.

24. Respondent's records for EH include a form signed by respondent dated July 20, 1998 addressed to "whom it may concern" which states that EH has been under his care for painful wrists and that he has diagnosed her with ganglionic cysts, tendonitis, myositis in both arms, and carpal tunnel. The form reflects that EH would be able to return to light duty at work on November 26, 1998. Respondent made no reference in this letter to

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2. The patient has been referred to by her initials, EH, in this Accusation to protect her privacy. Her name will be revealed to respondent in response to a request for discovery.

any concerns of the foot or ankle.

25. Respondent's progress notes for EH, in which each entry has been initialed or signed by respondent, reflect that respondent saw EH on July 27, 1998, July 30, 1998, August 3, 1998, August 6, 1998, August 13, 1998, August 18, 1998, August 20, 1998, August 23, 1998 (a Sunday), August 27, 1998, August 31, 1998, September 1, 1998, September 8, 1998, September 18, 1998, September 24, 1998, and September 28, 1998, that she had complaints concerning both wrists and arms associated with movement, grasping, and reaching, that he observed slight swelling medially at the scaphoid radial joint, and that he had diagnosed her with degenerative osteoarthritis, ganglionic cyst at the scaphoid radial joint, tendonitis, ligamentous inflammation, and myositis of the muscles of both arms.

26. The progress notes reflect that on each of these dates respondent treated EH's wrist and arm condition with strapping, ultrasound, and trigger point injections and conducted range of motion exams and muscle testing. Respondent made no reference in his progress notes to the diagnosis or treatment of conditions of the foot or ankle.

27. On August 17, 1998, respondent ordered x-rays of EH's wrists.

28. In a letter to Unum Life Insurance Company of America ("Unum") signed by respondent and dated September 28, 1998, respondent stated that EH had been under his care for her wrist discomfort. He noted that "[a]fter working as a typist and key punching for several years [EH] develop[ed] pain of both her wrist and forearms."

29. Under "Physical Examination," the September 28, 1998 letter to Unum includes, among other things,

> "Range of Motion: Internal and external rotation at the arms and wrist was painful, flexsion [*sic*] and extension of the wrist was painful. Patient could flex at the tarsal and phlangeal [*sic*] area but could not grasp with force sufficient to pick [up] or hold 1/2 lb or over." The letter makes no reference to the range of motion of EH's feet or ankles.
>
> "Neurologic Assessment: Sharp dull sensation of both arms was deminished

[*sic*], reflexes deminished [*sic*] bilaterally. Palpation of the wrist and forearm was acutely uncomfortable. This suggested inflammation of tissues surrounding the lateral nerves and other structures of the arms and wrist." The letter makes no reference to a neurologic assessment of EH's feet or ankles.

"Musculoskeletal: There was muscular tenderness at the the [*sic*] forearm." The letter makes no reference to a musculoskeletal assessment of EH's feet or ankles.

30. Respondent stated his diagnosis of EH in the September 28, 1998 letter to Unum as ganglionic cyst and tendonitis and he stated in the "Discussion and Opinion" section of the letter that "[t]here is no doubt that Ms [H] suffered from carpa[l] tunnel syndrome, the difficulty has rendered this patient temporarily disable[d]. This restriction of joint motion becomes a problem when the supporting structures are injured. This patient is encourage[d] to see the surgeon, with consideration of surgery." Nowhere in his "Discussion and Opinion" did respondent refer to EH's feet or ankles.

31. The only reference to lower extremities at all in the September 28, 1998 letter to Unum is under "Vascular Evaluation," where it states "[s]he had normal posterior tibial, popliteal and dorsalis pedis pulses of both lowere [*sic*] extremities."

32. While the only treatments reflected in respondent's progress notes for EH are strapping, ultrasound, and trigger point injections with 3.5 cc xylocaine, the September 28, 1998 letter to Unum states that EH was treated with electrical stimulation, iontophoresis, strapping, ultrasound, Motrin 600 mg., Vicodin ES, and Valium 10 mg.

33. Respondent's records for EH contain two undated letters to "whom it may concern," both signed by respondent. Both state that EH has been under his care for complaints of painful wrists, that he has diagnosed her with carpal tunnel syndrome, ganglionic cyst, ligamentous strain, and tendonitis, and that the diagnoses have rendered her unable to perform her normal job functions. The letters describe pain with holding, grasping, and reaching out, pain at the finger tips with long term dangling of arms, and pain when lifting over two pounds. The letters describe EH as currently disabled with guarded

prognosis.

34. In a letter to "whom it may concern" signed by respondent and dated September 28, 1998, respondent stated that EH had been under his care with complaints of "painful ganglionic cyst and carpal tunnel syndrome ligamentous and tendonitic strain." He stated that EH had severe pain with digital flexion, grasping, and reaching out so he had advised her to avoid these activities. He noted that EH was currently disabled and that her prognosis remained guarded.

35. Respondent does not have a physician's and surgeon's certificate to practice medicine in the state of California.

36. Respondent's master billing record for EH dated September 26, 1998 reflects as follows:

DATE	SERVICE CODE	CHARGE	PAID	BALANCE
7/27/98	97128, 95851	80.00	40.00	40.00
7/30/98	97014, 29540	80.00	40.00	80.00
8/3/98	95851	40.00	40.00	80.00
8/6/98	97014, 29540	80.00	40.00	120.00
8/13/98	97128	40.00	40.00	120.00
8/18/98	97014, 29540	80.00	40.00	160.00
8/20/98	97128	40.00	40.00	160.00
8/23/98	97014	40.00	40.00	160.00
8/27/98	97128	40.00	40.00	160.00
8/31/98	97014, 29540	80.00	40.00	200.00
9/1/98	97128	40.00	40.00	200.00
9/8/98	97014, 29540	80.00	40.00	240.00
9/18/98	95851	40.00	40.00	240.00
9/24/98	97014, 29540	80.00	40.00	260.00
9/28/98	95851	40.00	40.00	260.00

37. Individual billing forms, however, reflect different dates, different service codes, and different charges, as follows:

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DATE	SERVICE CODE	CHARGE	PAID	BALANCE
7/27/98	99212	40.00	40.00	0
7/30/98	99201, 99211	40.00	40.00	0
8/9/98	99201, 99211	30.00 (?)	30.00 (?)	0
8/24/98	99201, 99211	45.00	45.00	0
8/31/98	99201, 99211	45.00	45.00	0
9/1/98	99201, 99211	45.00	45.00	0
9/8/98	99201, 99211	45.00	45.00	0
9/18/98	99201, 99211	45.00	45.00	0
9/24/98	99201, 99211	40 or 45	40 or 45	0
9/28/98	99201, 99211	40 or 50	40 or 50	0

38. On October 30, 1998, respondent's probation officer, Everett Gremminger, an investigator for the Board of Podiatric Medicine, telephoned respondent and advised him that he would be scheduling an interview to be attended by Investigator Gremminger, the podiatric medical consultant Jerry Erben, D.P.M., and respondent.

39. On November 2, 1998, Investigator Gremminger telephoned respondent and left a message telling him that the interview would be held November 10, 1998 at 12:30 p.m. and asking him to bring, among other things, all his files concerning patient EH.

40. On November 4, 1998, Investigator Gremminger wrote a letter to respondent advising him again of the November 10, 1998 interview date and again describing the materials he was expected to bring to the interview.

41. At the November 10, 1998 interview, respondent told Investigator Gremminger and Dr. Erben that the reason he had agreed to treat EH was as a favor to one of his patients. This patient told him that no other physician had been able to provide EH with relief. Respondent also said that he had emotional concerns for EH.

42. Initially, respondent told Investigator Gremminger and Dr. Erben that EH had come to him for plantar fasciitis. When it was pointed out to him, however, that there was no mention of plantar fasciitis in EH's medical records, respondent changed his story. He said that he had treated EH's wrists with trigger point injections in the belief that he could do so under the aegis of acupuncture. He admitted, however, that he had had no training in acupuncture, had taken no courses in acupuncture, and had no acupuncture

license. He then stated that his acupuncture claim was a mistake, that it was "all a mistake."

43. Respondent admitted to Investigator Gremminger and Dr. Erben that he had authored the undated letters to "whom it may concern" in which he stated that Patient EH had been under his care for her complaint of painful wrists, reported her diagnoses as carpal tunnel syndrome, ganglionic cyst, ligamentous strain, and tendonitis, described the severe pain she experienced with digital flexion, grasping, and reaching out, and proclaimed her to be disabled.

44. Respondent admitted to Investigator Gremminger and Dr. Erben that he had authored the September 28, 1998 letter to "whom it may concern" in which he stated that Patient EH had been under his care for complaints of a painful ganglionic cyst, carpal tunnel syndrome, and ligament and tendon strain, described the severe pain she experienced with digital flexion, grasping, and reaching out, and proclaimed her to be disabled.

45. Respondent also admitted that he had written and signed the September 28, 1998 letter to Unum in which he stated, among other things, that EH had been under his care for her wrist discomfort.

46. Respondent admitted to Investigator Gremminger and Dr. Erben that he had treated EH for her upper extremity problems, that he knew that he was practicing beyond the scope of his license, and that he had no explanation as to why he had provided treatment beyond the scope of his podiatric medicine license.

47. As directed, respondent brought his file on patient EH to the November 10, 1998 interview. Respondent's file did not contain any records not already in the possession of the board and, except for some of the billing records and the lists of daily cash receipts for professional services from respondent's record book, respondent's file contained all of the records in the possession of the board.

48. The initial Accusation in this matter was filed and served on respondent on or about April 26, 1999.

49. On or about June 5, 1999, respondent provided the board with a

number of documents pursuant to its request for discovery. Among the documents provided were letters and medical records relating to respondent's treatment of EH.

50. In his cover letter to the board dated June 3, 1999, respondent stated that, among other things, he was providing the board with "corrected and uncorrected billings given to the insurance [company]. The uncorrected billing given the insurance [company] by the patient. Included are corrected and uncorrected reports."

51. Respondent provided the board with a letter signed by him and dated October 5, 1998 to "Num [Unum] Life Insurance Company of America" in which he stated that his office had provided the insurance company with records which were not reflective of the services he had provided to EH. Respondent claimed in the letter that the records previously provided were drafts which had been given to his typist to correct "erroneous sentences," that EH had seen him with complaints of painful ankles, and that he had practiced only within the scope of his podiatric medicine license. He noted that he was sending the insurance company "corrected records." The board had not previously seen this letter.

52. The "corrected records" referenced in the October 5, 1998 letter to Unum were not among the records respondent brought to his November 10, 1998 interview with Investigator Gremminger and Dr. Erben despite the fact that Investigator Gremminger had told him to bring ***all*** files concerning Patient EH. Moreover, respondent made no reference to these "corrected records" or to their contents during the November 10, 1998 interview.

53. Among the "corrected records" was a prescription form signed by respondent and dated July 20, 1998 for x-rays of EH's foot. The only prescription form for x-rays previously provided to the board was for x-rays of EH's wrists.

54. Among the "corrected records" was a letter to "whom it may concern" signed by respondent and dated September 28, 1998. This letter is very similar in form to the "uncorrected" September 28, 1998 letter described in paragraph 34, above. The

"corrected" letter, however, states that EH was under respondent's care for complaints of her lower extremities rather than of her wrists and arms, and that she was under the care of Dr. Sheryl [Shirley] Tucker Harris for her ganglionic cyst, carpal tunnel syndrome, and ligament and tendon strain which, in the original, "uncorrected," September 28, 1998 letter, respondent had claimed to be treating himself. The "corrected" letter states, as does the "uncorrected" letter, that EH described severe pain with digital flexion, grasping, and reaching out but the "corrected" letter adds the admonition that restrictions related to EH's upper extremities would have to be deferred to Dr. Harris for comment. Finally, the "corrected" letter states that EH has swelling and tenderness of the ankles, that she was to avoid long standing, and that she was currently disabled due to the problems with her lower extremities. As noted in paragraph 34, above, the "uncorrected" September 28, 1998 letter to "whom it may concern" made no reference to EH's lower extremities.

55. Dr. Shirley Tucker Harris did not treat EH for her upper extremity complaints during this period.

56. Among the "corrected records" was a letter to Unum signed by respondent and dated September 28, 1998, in which respondent stated that EH had been under his care for her foot and ankle pain. This letter is very similar in form to the "uncorrected" September 28, 1998 letter to Unum described in paragraphs 28 through 31, above, in which respondent stated that EH was under his care for wrist problems. Respondent noted in the "corrected" letter, as he had in the "uncorrected" letter, that "[a]fter working as a typist and key punching for several years [EH] develop[ed] pain of both her wrist and forearms." In the "corrected" letter, however, respondent added that EH "also [had] painful ankle and knee with long standing and walking." As noted in paragraphs 28 through 31, above, the "uncorrected" letter refers only to the diagnosis and treatment of EH's upper extremity complaints while the "corrected" letter reflects only treatment of lower extremity complaints.

57. The "corrected" September 28, 1998 letter to Unum states, under "Past

Medical History," "Musculoskeletal: Painful left knee and ankle" and "Neurological: Admits to tingling pain of her forearm and wrist and lowere [*sic*] legs and ankle."

58. Under "Physical Examination," the "corrected" September 28, 1998 letter to Unum states, among other things,

> "Range of Motion: Inversion and eversion motion was painful right greater than left. Dorsiflexsion [*sic*] of the and [*sic*] plantarflexsion [*sic*] was painful right greater than left."
>
> "Gait: The patient walked with a limp all with the purpose of avoiding further inflammation of the post injured lateral site of the right knee and ankle. With strapping she was able to ambulate about a 1/2 block then She [*sic*] had to stop or slow down in order not to over stress the turgor of the strapping. She also experienced radiating pain on the right leg after prolong[ed] walking or standing."
>
> "Neurologic Assessment: Sharp dull sensation of the was [*sic*] deminished [*sic*], reflexes on the right deminished [*sic*] and left was normal. Palpation of the lateral right foot was acutely uncomfortable. This suggested inflammation of the tissues surrounding the lateral nerves and other structures of the right knee and ankle."
>
> "Musculoskeletal: There was muscular tenderness at the the [*sic*] forearm through out the, [*sic*] painful ankle with dorseflexsion [*sic*] and plantarflexsion [*sic*] inversion and eversion, right greater than left."

59. Respondent's "Diagnosis" in the "corrected" September 28, 1998 letter to Unum was

> "1. Ganglionic cyst, tendonitis, Ankle
>
> "2: possible tenosynovitis ankle right
>
> "3: painful wrist suggestive of carpal tunnel syndrome as per Dr Harris
>
> "4: lateral knee pain
>
> "5: possible rheumatiod [*sic*] arthritis. bilateral [*sic*] ankle."

60. Respondent stated in the "Discussion and Opinion" section of the "corrected" September 28, 1998 letter to Unum that "[t]here is no doubt that Ms [H] suffered from severe pain to her ankles and knee. The resulting right knee and ankle [*sic*] has made ambulation difficult and has rendered this patient temporarily disable[d]. There is pain with inversion, eversion plantar and dorseflexion [*sic*] of the ankle. Weight baring [*sic*] is a problem when the supporting structures are inflamed. This patient['s] medical problems will be discussed with Dr Harris and further diagnostic consideration will be discussed. This patient has not progressed sufficiently at this times [*sic*] and has not been release[d] from my care [at] this time."

61. Also among the "corrected records" respondent provided to the board on June 5, 1999 was a master billing record for EH dated September 26, 1998 which reflects different dates, service codes, and charges than the master billing record also dated September 26, 1998 described in paragraph 36, above.

62. The "corrected" master billing record for EH reflects as follows:

DATE	SERVICE CODE	CHARGE	PAID	BALANCE
7/20/98	29540	40.00	40.00	40.00
7/27/98	99212	40.00	40.00	00.00
7/30/98	99212	40.00	40.00	00.00
8/9/98	99212	40.00	40.00	00.00
8/18/98	99212, 29540	80.00	40.00	40.00
8/20/98	99212	40.00	40.00	80.00
8/24/98	99212, 29540	80.00	40.00	120.00
8/27/98	97128, 99212	40.00	40.00	120.00
8/31/98	99212	40.00	40.00	00.00
8/27/98	99212	40.00	40.00	00.00
8/31/98	99212	40.00	40.00	00.00
9/1/98	99212	40.00	40.00	00.00
9/8/98	99212	40.00	40.00	00.00
9/18/98	99212	40.00	40.00	00.00
9/24/98	99212	40.00	40.00	00.00
9/28/98	99212	40.00	40.00	00.00
		Total balance	120.00	

63. Also among the "corrected records" respondent provided to the board on June 5, 1999 were progress notes for EH, initialed by respondent, which were very

similar in form to the "uncorrected" progress notes described in paragraphs 25, 26, and 32, above. The "corrected" progress notes reflect that EH complained of ankle pain and that respondent treated her on July 20, 1998, July 27, 1998, July 30, 1998, August 3, 1998, August 9, 1998, August 18, 1998, August 20, 1998, August 24, 1998, August 27, 1998, August 27, 1998 (there are two entries for August 27), August 31, 1998, August 31, 1998 (there are two entries for August 31), September 1, 1998, September 8, 1998, September 18, 1998, September 24, 1998, and September 28, 1998 with strapping, ultrasound, and trigger point injections and periodically conducted range of motion exams and muscle testing. The "uncorrected" progress notes refer only to the diagnosis and treatment of EH's upper extremity complaints.

64. The "corrected" progress notes reflect that respondent observed slight swelling medially and laterally at the ankle joint and that respondent had diagnosed EH with degenerative osteoarthritis, ganglionic cyst at the anterior lateral ankle, tendonitis of both wrists, ligamentous inflammation, myositis of the muscles of both arms, and myositis of both gastrocnemius (calf) muscles.

65. The first of the two entries for August 27, 1998 in the "corrected" progress notes reflects that EH complained of both ankle pain and wrist pain. No other reference was made in this entry to EH's wrist pain. The first of the two progress note entries for August 31, 1998 also reflects that EH complained of both ankle pain and wrist pain. This entry states that EH "was told that [*sic*] see her internist and that I,d [*sic*] see her for her lower extremity only." These are the only references to upper extremity pain in the "corrected" progress notes.

66. Also among the "corrected records" respondent provided to the board on June 5, 1999 is a modified copy of his July 20, 1998 written "assessment" and "plans" as described in paragraph 23, above. In the "corrected" document, respondent augmented the "uncorrected" assessment of EH, which reflected carpal tunnel, ganglionic cyst, and tendonitis of the elbow, with "tardal [*sic*] tunnel ankle right" and augmented the

"uncorrected" plans, which reflected trigger point injections with 3.5 cc xylocaine, with, among other things, x-rays of the foot and ankle.

67. Also among the "corrected records" respondent provided to the board on June 5, 1999 is a copy of a form which includes a category of "Chief Complaints" under which EH has written, in her own handwriting, "pains in both hands/wrists with numbness & swelling" and to which respondent has added, in his handwriting, "painful knees with standing" and "painful ankle right greater than left."

FIRST CAUSE FOR DISCIPLINE

(General Unprofessional Conduct; Violation of Medical Practice Act; Practicing Medicine Without Certificate)

68. Respondent's certificate to practice podiatric medicine is subject to disciplinary action under Business and Professions Code section 2234 and subsection (a) of section 2234, in conjunction with sections 2222 and 2497(a), for general unprofessional conduct and violating the medical practice act, respectively, in that respondent has violated section 2052 by exceeding the scope of the practice of podiatric medicine as described in section 2472 by diagnosing, treating, and prescribing for Patient EH's wrist and arm conditions and injuries, as more particularly alleged in paragraphs 16 through 67, above, most specifically in paragraphs 17 through 19, 23 through 35, and 41 through 47.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Failure to Maintain Adequate and Accurate Records)

69. Respondent's certificate to practice podiatric medicine is subject to disciplinary action under Business and Professions Code section 2234, in conjunction with sections 2222 and 2497(a), for unprofessional conduct pursuant to sections 2234, subsections (b) and (d) for gross negligence and repeated acts of negligence, respectively, and section 2266, in that his medical records and billing reports for patient EH are inconsistent with respect to the date of her first visit, the dates of her subsequent visits, what treatments he

was providing her, and how much and for which visits and what treatments he was billing her, as more particularly alleged in paragraphs 16 through 67, above.

THIRD CAUSE FOR DISCIPLINE

(Dishonesty, Fraudulently Altering or Modifying Medical Records, Fraudulently Creating False Medical Records, Making a False Document Related to the Practice of Podiatric Medicine)

70. Respondent's certificate to practice podiatric medicine is subject to disciplinary action under Business and Professions Code section 2234, in conjunction with sections 2222 and 2497(a), for unprofessional conduct pursuant to section 2234(e) for dishonesty, 2261 for knowingly making or signing documents directly related to the practice of podiatry which falsely represented the facts, and 2262 for altering and modifying medical records with fraudulent intent and for creating false medical records with fraudulent intent, in that, after being formally accused by the Board of Podiatric Medicine with practicing outside the scope of his license, he created new medical records for EH and modified old ones and provided them to the board to prove that he had not provided treatment for EH's complaints concerning her wrists and arms, as more particularly alleged in paragraphs 16 through 67, above.

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